



NORTH EAST VICTORIAN DIVISION OF GENERAL PRACTICE

## CHAIRS REPORT

As with all Divisions of General Practice around Australia we continue our slow but inexorable path towards the establishment of Medicare Locals. Our application for the second and third rounds of Medicare Locals has been submitted. While we await the outcome of the Government's deliberations we are now working closely with the Albury Wodonga GP network to create a transitional plan.

The key to the transition is to ensure that it is as seamless as possible. In this way we can assure our members that services to their practices will continue to be delivered as they are currently. Importantly, we can also offer some security of employment to our excellent staff.

Inevitably there will be some changes. We now know that some of our practices will ultimately be moved into the Goulburn Valley ML. These include those in the towns of Eildon, Alexandra, Yea and Yarrawonga. It is important for GP's in those towns to understand that we will work closely with Goulburn Valley to ensure that this does not diminish the delivery of services at the practice level. We will also gain some towns in Southern NSW with whom neither Albury Wodonga nor NE Vic have had a relationship before.

Please note that our AGM will be held at Lindenwarrah on 27<sup>th</sup> October. Put this date in your diaries and please make every effort to attend as it will be the **last ever AGM** for our Division. We want it to be a special social event and also an opportunity for you to discuss the future with the Board.

Remember that in the not too distant future we will have to be asking all members to vote on major changes to our organisation that will involve significant constitutional change or winding up of the company. So we aim to keep you as informed as possible. I look forward to seeing you at the AGM.

**Dr. Wendy Connor**  
*Chair - North East Victorian Division of General Practice*



INSIGHT



### INSIDE THIS ISSUE:

Close the Gap - Dr. Bruce Slonim	Page 2
Rural Primary Health Services Report - Sandra Beirs	Page 4
Reporting the HbA1c - Janet Lagstrom	Pages 5,6 & 7
Irritable Bowel Syndrome (IBS) - Jo Morshead	Page 9
LAOS Program Report - Mandy Ditcham	Page 10
Telehealth - Vimal Pasupathy	Page 14
Finding Evidence - Recognising Hype	Page 15

## MEMBERS MARK THIS DATE IN YOUR DIARY

The North East Victorian Division of General Practice Annual General Meeting

Date: 27 October 2011

Venue: Lindenwarrah, Milawa

Drinks 6pm – 7pm - Dinner from 7pm

The formal process of the meeting will be held throughout your dinner.

Lindenwarrah is offering a special accommodation rate for members wishing to stay.

Accommodation bookings are to be made by contacting Lindenwarrah directly on 03 5720 5777

## CLOSE THE GAP

There are many indigenous communities in remote areas of Australia without GPs. The health clinics in these communities are usually staffed by the most wonderful, dedicated and experienced remote area nurses with support from local aboriginal workers. GP support might be by distant phone, fly in fly out visits or occasional locum stints. These communities and the health clinic staff need and deserve better GP support. The burden of disease in many of these communities is immense and if there is to be a “Closing of the Gap”, GPs of Australia need to be part of the team that get out there and spend time in these communities. We sit comfortably in our surgeries unaware or oblivious to the need and how a small commitment could be of enormous help. As little as two weeks as a locum can make a difference and you may well find it changes your life. Red dirt, blue skies, great country and the chance to see first hand how strong aboriginal culture still remains is all part of the experience. Flights, accommodation and vehicle are always supplied and families will always be made very welcome. Most clinics are fully computerised with internet access, and have an excellent support base of specialists and allied health providers not too far away. Strong emergency skills are not necessary and there are always the Flying Doctor and Base Hospitals for support.



I am now in Ampilatwatja for the third time, a community 320kms NE of Alice Springs. It has a population of around 500, is a dry and very functional community but as everywhere else has a high incidence of chronic disease. The clinic is staffed by three experienced Remote Area Nurses, a practice manager (also a RAN) along with indigenous health support workers, driver and receptionist.



The clinic is fully computerised (Communicare) and has satellite internet access. Great clinical support, when needed, is provided by Alice Springs Hospital as well as the Royal Flying Doctor Service.

All after hour's presentations are managed by the nursing staff but on rare occasions GP input may be requested. Very little procedural work is necessary and other than every day ED skills no other skills are specifically required.

It is unlikely clinics such as this will be able to attract a full time GP but if there were a number of GPs that could adopt a community and provide regular GP support it will certainly make a difference. I would encourage GPs to consider these opportunities and I can promise it will change your life. A starting point would be to contact Tracey Merton, the Locum Coordinator at General Practice Network NT on 08 8982 1064 or <http://www.gpnnt.org.au> or other state health departments and they would love to hear from anyone seeking further information. I would also be pleased to provide any information. Is it time more GPs take responsibility for the care in remote areas for our indigenous population?

**For more information regarding “Closing the Gap” please contact Dr. Bruce Slonim at the Corowa Medical Centre on 0419 244 772 or via email [bjslonim@bigpond.net.au](mailto:bjslonim@bigpond.net.au)**

## ***MALNUTRITION IN EAST TIMOR***

As many of you will know I have been doing some voluntary work in East Timor over the past seven years. The nature of my involvement there has changed with time as conditions have changed in Timor. For several years, along with another of our North East GP's, Mal Altson, I worked in a government medical clinic on Atauro Island. The clinic is now well staffed by Cuban doctors.

My role more recently has been in association with the Indigo Shire – Atauro Island Friendship Group. We have various programs running on Atauro Island including a tertiary scholarship program, school support, composting toilets and malnutrition relief. Most of these are in partnership with local organisations.

The malnutrition relief program is run by an East Timorese NGO called HIAM Health. On the island they identify children under 5, and pregnant and lactating women with moderate to severe malnutrition. They provide them with supplementary food along with an education program for the families.

In Dili, HIAM Health runs a residential malnutrition rehabilitation centre which houses up to 25 malnourished children and their families at a time. During my recent visit in July, I spent a week at the centre, training staff and volunteer health workers from the districts.

They do a fabulous job, frequently without adequate training and equipment. One of the deficiencies I noted was the lack of a glucometer. Hypoglycaemia is one of the most common causes of death in a child with severe malnutrition.

I am delighted that Roche have donated a glucometer and test strips to this worthy cause. We will arrange for these to be taken to Dili as soon as possible. Potentially, this simple measure could save the lives of children, so a big thank you to Roche.



Educating parents at malnutrition rehab centre in Dili.

***By Dr. Wendy Connor***

## ***GP PSYCH SUPPORT***

GP Psych Support offers free mental health patient management advice, from a psychiatrist, within 24 hours. This convenient service is available to GPs 24 hours a day, seven days a week, every day of the year.

GP Psych Support's psychiatrists are able to provide advice on all patient mental health issues. Common enquiries include: diagnosis; changes to medications and dosages; management; and referral options, in the areas of: perinatal; child and adolescent; drug and alcohol; general adult; and old age psychiatry.

GPs can submit a patient enquiry by telephone (1800 200 588), facsimile (1800 0124 22) or the using the [secure website](#), and a psychiatrist will respond to their enquiry within 24 hours. GPs also have the added flexibility of being able to select how the psychiatrist will respond to their enquiry (phone, fax or webmail) and if selecting phone, a particular time that they will be available to discuss the enquiry, with the psychiatrist.

GPs need to register once to access the service; if you have already registered, however misplaced your login details you can request them by contacting the service on 1800 200 588.

For more information, to register, or to see example enquiries and resources please visit the website [www.psychsupport.com.au](http://www.psychsupport.com.au) Telephone: 1800 200 588 or Fax: 1800 012 422 (use the faxback form downloadable on the website)

## ***RURAL PRIMARY HEALTH SERVICES***

### **RURAL PRIMARY HEALTH SERVICES PROGRAM 2011 - 2012**

From July 1<sup>st</sup> 2011 the Rural Primary Health Services Program started another twelve months of providing funding for allied health services to be delivered to all Practices in the Division. New contracts were developed with seventeen organisations to provide the services as well as continuing on with services provided by Division employees Janet Lagstrom (Diabetes Educator) and Joanne Morshead (Dietitian).

Six disciplines of allied health are to be delivered to twenty-nine Practices in nineteen towns. The services and the towns these will be delivered to include:

Diabetes Education at

Alexandra	Beechworth	Benalla	Bright
Chiltern	Eildon	Mansfield	Mount Beauty
Rutherglen	Violet Town	Wangaratta	Yackandandah
Yarrowonga			

Dietetics at

Beechworth	Benalla	Bright	Chiltern
Euroa	Mansfield	Myrtleford	Mount Beauty
Rutherglen	Violet Town	Wangaratta	Yackandandah
Yarrowonga			

Psychology at Benalla & Alexandra

Physiotherapy at Corryong & Tallangatta

Podiatry at Myrtleford, Wangaratta & Yea and

A Youth Worker at Walwa.

Further information or assistance relating to the program is available from:

**Sandra Beirs**

**Rural Primary Health Services Program Manager**

## ***R U OK? DAY***



RU OK? Day is a national day of action which aims to prevent suicide by encouraging Australians to connect with someone they care about and help stop little problems turning into big ones.

On that day we want everyone across the country, from all backgrounds and walks of life, to ask family, friends and colleagues: "Are you OK?".

Staying connected with others is crucial to our general health and wellbeing. Feeling isolated or hopeless can contribute to depression and other mental illnesses, which can ultimately result in suicide. Regular, meaningful conversations can protect those we know and love.

It's so simple. In the time it takes to have a coffee, you can start a conversation that could change a life.

For more information visit [www.ruokday.com.au](http://www.ruokday.com.au)

## MENTAL HEALTH

### BUDGET CHANGES TO MENTAL HEALTH ITEMS

In the Federal Budget it was announced that there will be changes to Mental Health MBS rebates for GPs which will commence on 1 November 2011. GPs will be paid for the actual time they spend on developing a Mental Health Treatment Plan, with an incentive for GPs who have completed Mental Health Skills Training (MHST).

	Current MBS Item	From 1 <sup>st</sup> November 2011 will be replaced by
<b>GPs who have completed MHST</b>	2710 - \$163.35 rebate	Level D (40+ mins) - \$126.43 rebate Level C (20-39 mins) – \$85.92 rebate
<b>GPs who have <u>not</u> completed MHST</b>	2702 - \$128.20 rebate	Level D (40+ mins) - \$99.55 rebate Level C (20-39 mins) – \$67.65 rebate

Changes will also occur to the Medicare Benefits Schedule fee structure for the GP Mental Health Review item 2712 and the GP Mental Health Consultation item 2713. From 1 November 2011, the rebate for both items 2712 and 2713 will be reduced to \$67.65. This rate applies to all GPs regardless of whether or not they have completed MHST.

There will also be changes to the number of sessions that will be available to patients from Better Access providers for focused psychological services. The number of sessions will be reduced from 12 per calendar year to 10 (6 sessions initially plus an additional 4 if required). No additional sessions in “exceptional circumstances” will be permitted. Patients will also be eligible for a total of 10 group sessions per calendar year in addition to their individual sessions.

**Natalie Orgias**  
Mental Health Program Manager

## REPORTING THE HbA1c

### IFCC UNITS STARTING JULY 2011

The new HbA1c result will look very different to results obtained on blood glucose meters – a huge advantage to reduce confusion in conflict results

The number values are larger making variations in HbA1c results over time appear more significant

The new reporting method is in keeping with the recent international consensus document ‘2010 Consensus Statement on the worldwide standardization of the haemoglobin A1c measurement’. To avoid any confusion the International Federation of Clinical Chemistry and Laboratory Medicine (IFCC) has agreed to report the test using substantially different number values recorded in mmol/mol (or stated as milli-moles per mole).

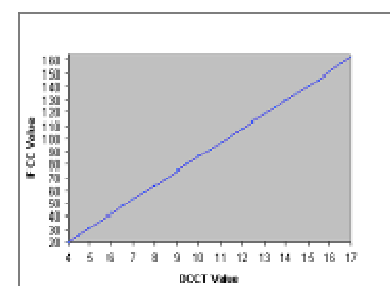
The algorithm for this conversion is known as the “Master Equation”:

**SI HbA1c unit** (mmol/mol) = 10.93 x NGSP unit (%) - 23.50

e.g.. 6% (DCCT) = 42 mmol/mol (IFCC)

or simply

For a rough conversion from mmol/mol to HbA1c  
**“Add two”** E.g. 53 – “5” add “2” = 7%

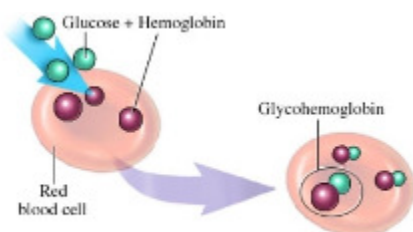


Continued over page

## REPORTING THE HbA1c CONT.

### What is HbA1c?

Haemoglobin (Hb) is the iron containing oxygen-transport protein in red blood cells. Glycated haemoglobin (GHb) is formed by the attachment of glucose to various amino acids of the most common Hb protein, haemoglobin A (HbA). Since erythrocytes are freely permeable to glucose, the level of GHb in a blood sample provides a glycaemic history of the previous 120 days, the average erythrocyte life span. GHb most accurately reflects the previous 2-3 months of glycaemic control.



The more **glucose** present over time, the more HbA1c is produced.  
HbA1c test reports the amount of HbA1c as a proportion (%) of the total haemoglobin

### Benefits of reporting the HbA1c

The Diabetes Control and Complications Trial (DCCT) 1983 – 1993, showed the importance of HbA1c as a measure of long term diabetes control. Any drop in HbA1c result was beneficial. A one per cent drop reduced the likelihood of developing diabetes complications significantly, equating to a 21% reduction in death, 37% reduction in microvascular complications (retinopathy and neuropathy) and a 14% reduction in heart attack.

The DCCT proved conclusively that tight blood glucose control in type 1 diabetes reduces risk of long term complications:

Eye disease	76% reduced risk
Kidney disease	50% reduced risk
Nerve disease	60% reduced risk

Any reduction on HbA1c is very beneficial, the sooner the better!

### Targets based on DCCT / UKPDS findings:

International Diabetes Federation (IDF) - HbA1c less than 6.5%

### The DCCT highlighted the need for standardised and accurate HbA1c assays for use in all laboratories

#### Disadvantages of current reporting method: HbA1c measurements

Many different types of GHb assay methods are available to the routine clinical laboratory. Methods differ considerably with respect to the glycated components measured, interferences, and non-diabetic range. The method for measuring HbA1c during the DCCT has since been found to have interferences falsely elevating the results.

Test results from newer calibration methods, can report the accurate value without interferences, however, results have been adjusted to align to the old DCCT method. For example - HbA1c test during the DCCT, giving a result of 8%, is now known to be an elevated result due to interferences making up about 1.6% of the value. Modern Pathology methods would give a more accurate result of 6.4%.

Scientists and clinicians worldwide, instigated by the IFCC (International Federation of Clinical Chemistry and Laboratory Medicine), have agreed that it is no longer tenable to report results, which, they know to be falsely elevated and that a new standard based on modern accurate methods should be adopted globally. The US established the National glycohaemoglobin standardisation program (NGSP) in 1996(1).

#### Why is the standardisation of reference methods so important?

- Improved intra and inter laboratory results give clinicians more confidence to adjust treatment.
- There is a move internationally to use the HbA1c as a diagnostic tool
- Diabetes centres and facilities may be assessed on the basis of patients achieving HbA1c targets.
- Certain diabetes medications can only be prescribed on the basis of the patients HbA1c result.

## REPORTING THE HbA1c CONT.

### HbA1c Conversion Table to International Units expressed in mmol/mol

DCCT % HbA1c	IFCC mmol/mol HbA1c
4	20
4.5	26
5	31
5.5	37
6	42
6.5	48
7	53
7.5	58
8	64
8.5	69
9	75
9.5	80
10	86
10.5	91
11	97
11.5	102
12	108
12.5	113
13	119
13.5	124
14	130
14.5	135
15	140
15.5	146
16	151
16.5	157

For whole numbers between 4 and 13 “minus two minus two”

$$7\% = 53\text{mmol/mol}$$

$$7 - 2 = 5 (-2) 3$$

Some of the key treatment target numbers to become familiar with are:

**6.5% is 48 mol/mmol**

**7.0% is 53 mol/mmol**

**7.5% is 58 mol/mmol**

#### Around the globe:

A number of countries report the new method. These countries include NZ, UK, Germany, Holland, Italy and Sweden. A few countries continue to convert the new result to the old HbA1c. This includes the USA and Canada

#### In Australia:

The HbA1c working party has recommended that for 2 years from mid 2011 to mid 2013 in Australia both results HbA1c and mmol/mol (IFCC) will be reported

e.g. HbA1c 6.0% HbA1c 42 mmol/mol (IFCC)

After the two year period expires the new method only will be reported

e.g.. **HbA1c 42 mmol/mol (IFCC)**

#### The estimated Average Glucose Value (eAG)?

The estimated Average Glucose (eAG) is an estimate based on the correlation between self monitoring blood glucose (multiple averaged) and HbA1c results. The evidence for reporting in this manner has been based on a study known as the ADAG study (3). In the past two years, the eAG has been reported to assist comparison with the patient's hand held meter. The validity of reporting in this manner has been questioned with a wide degree of “scatter” around the correlation line between the HbA1c result and the eAG in the ADAG study(4). The Australian HbA1c Working Party does not endorse the reporting of the eAG.

#### References:

- 1.W Garry John, Andrea Mosca, CasWeykamp, Ian Goodall(2007). "HbA1c Standardization: History, Science and Politics." ClinBiochemReview : November; 28(4): 163-168

HanasR, John G on behalf of the International HbA1c Consensus Committee. 2010 Consensus Statement on the Worldwide Standardization of the HemoglobinA1c Measurement Clinical Chemistry 56:8,1362-1364 (2010)

[Nathan DM, KuenenJ, Borg R, ZhengH, SchoenfeldD, Heine RJ for the A1c-Derived Average Glucose \(ADAG\) Study Group: Translating the hemoglobinA1c assay into estimated average glucose values. Diabetes Care 2008, 31:1473-8](#)

Kilpatrick, E S Estimated average glucose (eAG): fit for purpose? Diabetic Medicine, Aug 2008, Vol 25 Issue 8, p899-901

**Janet Lagstrom**  
**Credentialed Diabetes Educator**

**CONTINUED PROFESSIONAL DEVELOPMENT**

**INFECTION CONTROL WORKSHOP**

The Division held an Infection Control workshop in August which was presented by Marg Jennings, Microbiologist and Infection Control Educator.

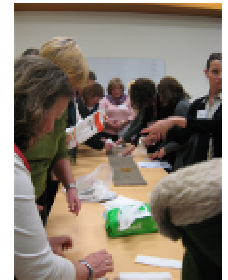
The aim of the workshop was to provide participants with the steps involved in instrument processing competency and build on current knowledge in infection control.

32 participants attended on the night including practice nurses and practice staff.

Marg presented to participants items included in a spill kit and demonstrated cleaning up different spills on carpet and linoleum with the participants then given the opportunity to have hands on experience.

When asked upon evaluation what did they like most about this session participants responded with:

- “The down to earth manner of instruction”
- “Spill Kits”
- “In groups, with hands on practical use”
- “Practical demonstrations, friendly present and organisers”
- “Having a go at doing the clean ups”
- “Visual aids, relates to work situations”



Attendees getting some hands on experience



**PAEDIATRIC SURGICAL CONDITIONS – WHEN TO REFER**

The Division held a Paediatric Surgical Conditions – When to refer workshop in August which was presented by Dr Tracey Merriman, paediatric surgeon from Albury.

The aim of the workshop was to provide participants with the knowledge of when kids need to be referred and with what urgency.

21 GPs and 5 Medical Students attended on the night. When asked upon evaluation what did they like most about this session participants responded with:

- “Targeted approach to common surgical problems with paedes”
- “Relevance of material presented”
- “Good background and introduction to paediatric surgery”
- “Conditions which require referral”
- “Best speaker I have heard this year – Tells us what GPs need to know”
- “Recognising paediatric patients who need urgent referral and who do not”
- “Short and Sweet, Precise and accurate”

Learning Objectives	Partially met	Entirely met
Knowledge of clinical circumstances in which referral to a Paediatric Surgeon is appropriate	8%	92%
Awareness of signs & symptoms of common paediatric surgical conditions	12%	88%
Understanding of serious or potentially serious surgical conditions not to be missed	4%	96%



GPs & Medical students attending the Paediatric Surgical Conditions Workshop



Dr Tracey Merriman accepting a thank you gift from Holli Davis

**Holli Davis & Rosslyn Makin  
Business Development Team**

## IRRITABLE BOWEL SYNDROME (IBS)

### Irritable Bowel Syndrome

- IBS is common, affecting 1 in 7 adults.
- IBS features gastrointestinal symptoms:
  - Bloating
  - Distension
  - Altered bowel habit (constipation or diarrhoea or both)
  - Wind
  - Abdominal pain
- It is important that individuals with gastrointestinal symptoms are investigated to rule out serious gastrointestinal disorders e.g. inflammatory bowel disease, coeliac disease and bowel cancer before the diagnosis of IBS is made.

### What common foods trigger IBS?

- Caffeine
- Alcohol
- High fat foods
- Gluten (protein in grains wheat, rye, barley & oats)



Recent research has identified other foods, namely sugars, which are poorly absorbed in the small intestine and are therefore fermented by bacteria resulting in production of gas. This group of sugars is known as FODMAPs™ (Fermentable Oligo-saccharides, Mono-saccharides and Polyols). These sugars can be found in many different foods.

### FODMAPs™

Fructose – a sugar found in fruit, juice and honey

Lactose – a sugar found in milk and dairy products

Polyols (sorbitol and mannitol) – found in artificial sweeteners, some vegetable and fruits

Fructans and fructo-oligo-saccharides – found in onion, garlic and grains wheat and rye

Galacto-oligo-saccharides – found in legumes e.g. lentils, baked beans



- FODMAPs™ are very small in size.
- There is a wide range of food containing 1 or more FODMAPs™. Generally these are from the food groups: fruit, vegetables, grains and cereals and dairy.
- Protein foods including meat, chicken, fish and eggs do not contain FODMAPs™.

### FODMAPs™ and IBS

Malabsorbed FODMAPs™ produce an osmotic effect in the gut, drawing water into the bowel, which can result in diarrhoea.

Alternatively, the malabsorbed FODMAPs™ can pass into the large intestine where bacteria ferment them and produce gas. This can lead to bloating, nausea, abdominal pain and general discomfort. This gas production can slow transit of bowel contents which can result in constipation.

### Nutritional Management of IBS

Low FODMAP™ Diet – restricting all or select FODMAPs™.

After 6-8 weeks following a Low FODMAP™ Diet, reintroduction of eliminated foods to identify triggers and tolerance levels.

Seek the advice of a dietitian to manage your patients with IBS.

**Jo Morshead**  
Dietitian

## ***NEW NPS PROGRAM***

### **BALANCING BENEFITS AND HARMS OF ANTIPSYCHOTIC THERAPY**

North East Victorian Division of General Practice, in partnership with NPS, is offering a program on the safe and effective use of antipsychotic therapy in schizophrenia, bipolar disorder and behavioural and psychological symptoms of dementia.

This program provides a valuable opportunity to discuss up-to-date, independent, practical, evidence-based information on current therapeutic issues with a highly skilled NPS facilitator and other general practitioners.

#### **This program will focus on:**

An individualised approach in assessing benefits and harms of antipsychotic therapy

Tips to engage patients/carers in recognising and managing adverse effect

Ways to reinforce to patients the importance of adherence to antipsychotics when prescribed

A planned approach to assess the ongoing need for antipsychotics for behavioural symptoms of dementia

#### **What's in it for you?**

An opportunity to discuss evidence-based information and access key resources

Time-efficient education with the NPS facilitator

A Quality Prescribing Initiative (QPI) activity within the Practice Incentives Program and eligible for RACGP QA & CPD and/or ACRRM program points

**Holli Davis**

**NPS Manager**

## ***LIMITED ADVERSE OCCURRENCE SCREENING***

### **A CLINICAL RISK MANAGEMENT PROGRAM FOR SMALL RURAL HOSPITALS**

LAOS aims to ensure that experience and knowledge is shared throughout the rural hospital and medical profession in a non-threatening manner leading to quality improvement in participating rural hospitals. LAOS has resulted in a cultural change, from an attitude of individual blame to one that acknowledges system and process causes for adverse events.

Did you know that there are 12 small rural hospitals and over 100 GP's that are involved with the LAOS Program in our division? Since starting in June, I have been out to visit 9 of our hospitals and will be visiting the remaining 3 soon. On talking to staff from these hospitals it has become apparent that sometimes management think that they are actively participating in the LAOS program, when actually the clinical coder or health information manager may not have sent patient records for review for several years. To combat this issue I will be sending out reports to the Chief Executive Officer's, and Quality Managers of each of the hospitals over the next month showing how many patient records they have actually sent in over the last few years. Hopefully this will stop this issue, as without hospitals providing records, the program is not able to run.

Our GP reviewers have been busy reviewing files and we have managed to clear the back log that had collected previous to me starting. 3 Recommendations were also sent out in July and I appreciate people and organizations that completed the feedback forms and returned them to me. Hopefully over the next few months the back log of recommendations will be cleared also, just in time for us to have our next reference panel at 7pm on November 23rd at Lindenwarrah in Milawa.

On an encouraging note, the pilot study "Adverse Outcome Screening for Emergency Presentations at Small Rural Hospitals" that commenced in 2008 at Mansfield District Hospital is almost complete. An interim report has been submitted to the Department of Health Victoria, and we wait eagerly to hear back from them. The final step for this pilot study will be completed at our reference panel in November. If you would like more information, or to see a copy of the report please contact me at the Mount Beauty Office on 03 5754 1226

Finally, if you would like any more information about the program I am happy to be of any assistance. My workdays are Tuesday, Wednesday and Thursday.

**Mandy Ditcham**

**Clinical Risk Manager**

## DOSE ADJUSTMENT FOR NORMAL EATING (DAFNE)

### BETTER MANAGEMENT FOR PEOPLE WITH TYPE 1 DIABETES

The Dose Adjustment for Normal Eating (DAFNE) program is a group education program for people with Type 1 diabetes. Northeast Health Wangaratta (NHW) has conducted 12 DAFNE programs so far, and is seeking interest from individuals who would benefit from participating in the program.

#### What is DAFNE?

DAFNE is a five day outpatient group education program that equips patients with strategies to self manage their insulin doses. During the DAFNE program, participants will learn how to:

- Count carbohydrates and calculate quick acting insulin doses according to carbohydrate intake;
- Correct blood glucose levels if needed;
- Adjust long acting insulin to approximate basal insulin requirements; and
- Evaluate their blood glucose patterns and adjust both quick acting and long acting insulin to attain blood glucose levels in the target range.

#### Who Can Attend DAFNE?

In order to attend the DAFNE program, the participant must satisfy the following criteria (as established by the OzDAFNE collaborative):

- have had type 1 diabetes for more than six months
- be at least 17 years of age;
- be able to speak, read and understand English;
- not be on an insulin pump;
- be willing to inject, test and record blood glucose levels at least four to five times per day;
- be able to attend all five days of the program, from 9am to 5pm each day for one full week; and
- be motivated to learn and trial new insulin adjustment strategies, and improve diabetes control

#### How is DAFNE Evaluated?

Biochemical, anthropometric, and quality of life data are collected before the DAFNE program and 12 months after completing the DAFNE program in order to measure the effectiveness of the program. This data is reviewed on a periodic basis by the OzDAFNE collaborative. This data has demonstrated the following benefits of the DAFNE program in Australia:

- improved HbA1c
- decreased incidence of severe hypoglycaemia
- improved quality of life
- slight decrease in weight

#### How to Refer:

To refer your clients to the NHW DAFNE program, please fax referrals to:

Northeast Health Wangaratta  
Community Health  
Fax: 5722 5419

Your clients can also refer themselves by telephoning NHW on the number below.

#### Want to Learn More?

For further information about the DAFNE program, please contact Liz Clancy (dietitian), Helen O'Donoghue (Diabetes Educator), or Josie Hill (Diabetes Educator) on 5722 5239, or visit the DAFNE website:

[www.dafne.org.au](http://www.dafne.org.au).

**Liz Clancy**

**Accredited Practicing Dietitian**

#### Feedback from NHW DAFNE graduates:

*DAFNE has "given me a new positive focus in life with my diabetes"*

*"there was so much good information, not only from the educators, but from people (Type 1s) in the course"*

*it's the "best thing I could have done for my diabetes"*

*"a brilliant course"*

*"I have found this course very helpful and will be much more confident with my management"*

## HELP 4 U

### SEXUAL HEALTH SESSIONS FOR YEAR 9 IN SCHOOLS

The Program aims at building relationships between adolescents and health professionals, and encourages young people to seek help when they need it for the many issues they face. It also educates GP's on the health needs of young adolescents, and gives a positive approach to providing a friendly manner when dealing with those needs at local practices. Being youth friendly encourages practices to be pro-active in helping with health outcomes for young people especially in areas of mental health and sexual health, where often adolescents are reluctant to talk about their concerns because they find it difficult or embarrassing.

July, August and September the *Help4U* Program has been far and wide across the Division, with workshops to be held at Corryong, Wangaratta, Alexandra, Yarrowonga, and more bookings coming in for Yea, Euroa and Myrtleford. New GP's, teachers and school nurses have been trained for the program with more booked in for training!!

It has been fantastic to see the number of people keen to get involved with the program, and give youth a focus in their practices. The feedback from the students show they are grateful for the effort that GP's put in by coming to the schools.

Some of the comments:

*"Helpful and really easy to understand."*

*"I thought it gave everyone a good understanding."*

*"It was really helpful but sometimes a bit awkward, thank you for coming we are all very grateful."*

*"I think the information given will be helpful in time."*

*"I thought it was really cool and helpful."*

*"The Help4U program was very interesting and I really enjoyed it."*

*"It helped out a lot with my understanding."*

*"Good work in telling us things we need to know."*

*"It was good to get all the information that we need to know."*

*"Very useful and educational ."*

*"Feeling confident about going to a doctor now."*

**Anne Shaw**

**Youth Health Manager**

## NATIONAL DIABETES SERVICES SCHEME

### DIABETES FACT SHEETS

The NDSS has translated ten Diabetes Fact Sheets into ten languages.

#### Diabetes Fact Sheets

#### Languages

What is diabetes?	• Arabic
Food choices for people with diabetes	• Chinese (both Traditional and Simplified script)
Physical activity and diabetes	• Greek
Blood glucose monitoring	• Italian
Hypoglycaemia and diabetes	• Korean
Insulin and diabetes	• Spanish
Medications for type 2 diabetes	• Turkish
Staying well	• Urdu
Depression and diabetes	• Vietnamese
Sick days and type 2 diabetes	

These resources are available to download from the NDSS Website - [www.ndss.com.au/en/Resources/Multilingual/](http://www.ndss.com.au/en/Resources/Multilingual/)

The *Gestational Diabetes: Caring for yourself and your baby* booklet has been translated into five languages. Arabic, Chinese (both Traditional and Simplified script) Turkish, Vietnamese and is available at : [www.ndss.com.au/en/Resources/Brochures--Booklets1](http://www.ndss.com.au/en/Resources/Brochures--Booklets1)

## NPS RADAR

### Dabigatran (Pradaxa) for stroke prevention in patients with non-valvular atrial fibrillation

#### Key points

- **Dabigatran is an oral anticoagulant**  
It is a direct thrombin inhibitor.
- **Dose titration and monitoring of prothrombin time are not required**  
Dabigatran is formulated as a capsule (150 mg or 110 mg) taken twice daily.
- **Dabigatran 150 mg twice daily reduced the absolute risk of stroke or systemic embolism by 0.6% per year compared with Warfarin**  
The incidence of stroke or systemic embolism did not differ between dabigatran 110 mg twice daily and warfarin.
- **Important differences in effectiveness were related to the quality of INR control in clinical trial patients**  
Consistently therapeutic warfarin may be as effective as dabigatran.
- **The overall rate of major bleeding did not differ between dabigatran 150 mg twice daily and warfarin**  
Dabigatran 150 mg twice daily increased the risk of gastrointestinal bleeding, but reduced the risk of intracranial bleeding.
- **There is no antidote to dabigatran-induced bleeding**  
As with all anticoagulants, tell patients to seek prompt medical attention for unexplained bruising, blood in the urine or black stools.
- **Dabigatran is contraindicated in severe hepatic and renal impairment (creatinine clearance  $\leq 30$  mL/min)**  
Consider dabigatran 110 mg twice daily in patients with moderate renal impairment (creatinine clearance 30–50 mL/min).

#### Evidence snapshot

What is known about this drug	Areas of uncertainty	What does NPS say?
<p>Dabigatran 150 mg twice daily reduced the absolute risk of stroke or systemic embolism by 0.6% per year compared with warfarin (relative risk [RR] 0.65, 95% confidence interval [CI] 0.52 to 0.81).</p> <p>Major bleeding rates were similar for dabigatran 150 mg twice daily and warfarin (3.32% vs. 3.57%, respectively; RR 0.93, 95% CI 0.81 to 1.07).</p>	<p>The safety and efficacy of dabigatran has not been established in patients at high risk of bleeding (Box 1).</p> <p>Safety data for dabigatran are limited to 2 years of follow-up.</p>	<p>Consider individual risks and potential benefits when choosing an oral anticoagulant. Patients with an INR consistently in the therapeutic range may <b>not</b> benefit from switching to dabigatran therapy.</p> <p>Dabigatran may be an option for:</p> <ul style="list-style-type: none"> <li>• warfarin-treated patients who find it difficult to maintain a therapeutic INR</li> <li>• those at increased risk of drug–drug or drug–food interactions with warfarin</li> <li>• those for whom regular INR monitoring is difficult or impractical.</li> </ul>

To download the full version click on [http://www.nps.org.au/health\\_professionals/publications/nps\\_radar/2011/august\\_2011](http://www.nps.org.au/health_professionals/publications/nps_radar/2011/august_2011)

## TELEHEALTH

### What is 'telehealth'?

A video consultation where a patient, accompanied by an eligible medical practitioner, undertakes a consultation via video conferencing to an eligible specialist, consultant physician or psychiatrist.

There must be an audio and visual link between the patient and the eligible medical practitioner in order for the patient to claim for the telehealth rebate.

### Who can provide 'telehealth' services?

It is available across the full range of medical specialists. Rebates for patient-end services are available for services provided by medical practitioners, nurse practitioners, midwives and practice nurses and Aboriginal health workers.

### What are those eligible areas?

The Medicare rebates are available to patients in remote, regional and outer metropolitan areas and residential aged care facilities and Aboriginal Medical Services throughout Australia.

### What is medical practitioner Incentives for 2011-12?

<b>Telehealth On-Board:</b> one-off, lump sum payment for eligible practitioners who provide at least one telehealth service		\$6,000
Telehealth Service (specialist):	an ongoing, quarterly payment based on # of telehealth consults hosted during a quarterly period	\$60
Telehealth Service (patient-end):		\$40
<b>Telehealth Bulk Billing:</b> paid each time a service is bulk billed		\$20

This service started from 1 July 2011 and the telehealth MBS items can be found at [www.mbsonline.gov.au/telehealth](http://www.mbsonline.gov.au/telehealth). There are 23 new item numbers available for the video consultation services. The complete guidelines for Telehealth will be released in October 2011 by the RACGP.

### Where do I find out more?

1. Medicare Australia : 1800 222 032 or [telehealth@medicareaustralia.gov.au](mailto:telehealth@medicareaustralia.gov.au)
2. Telehealth Incentive Payments :  
<http://www.medicareaustralia.gov.au/provider/incentives/telehealth.jsp>
3. Telehealth MBS item numbers : [www.mbsonline.gov.au](http://www.mbsonline.gov.au)
4. MBS Telehealth webpage :  
<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/mbsonline-telehealth-landing.htm>

**Vimal Pasupathy**  
**E-Health Coordinator**



## NATIONAL PRESCRIBING SERVICE (NPS)

### Finding Evidence — Recognising Hype

**Finding Evidence — Recognising Hype** is a free online learning program to improve prescribers' skills in assessing new medicines.

It provides access to resources for quickly locating evidence-based information about new medicines, and includes tips and tools for responding to patients' questions.

#### What the program offers

- Interactive learning with case-based activities you complete in your own time
- An introduction to high quality resources and tools for evidence based prescribing
- An understanding of the limitations of new medicines
- Effective ways to communicate risks and benefits to patients
- Shortcuts in appraising clinical trials and understanding the evidence
- A critical look at the role of promotional materials

Visit the [NPS Online learning site](#) for the complete list of learning objectives.

#### Earn professional development points in the 2011–13 triennium.

This activity is approved by:

- RACGP QI & CPD program, 40 points (Category 1)
- ACRRM Professional Development program, 6 PDP Core points
- Pharmaceutical Society of Australia, Group 2 activity, 12 credit points (available to all registered pharmacists for inclusion in their individual CPD plan)
- APEC on behalf of the Royal College of Nursing, Australia, 12 x Continuing Nurse Education points

**Finding Evidence — Recognising Hype** is a recognised activity for the Quality Prescribing Incentive (QPI) an incentive program of the Practice Incentives Program (PIP) for general practices.

#### General practitioner testimonials

*"A highly recommended activity, extremely useful and relevant to medical practice. I have widely disseminated this to my GP colleagues."*

*"One of the best learning experiences I have had the pleasure to partake in. I learnt a lot, it should be an essential activity for every GP."*

*"A very relevant and very useful module which has lead to immediate changes in my practice. Very clear and well presented."*

*"This is the best learning exercise I have done in years."*



## BOARD OF DIRECTORS

Chair: Dr Wendy Connor (03) 5728 1566  
Deputy Chair: Dr Libby Garoni (03) 5754 3400  
Treasurer: Dr Paul Duff (03) 5750 1000

## BOARD MEMBERS

Dr Matt Byrne (03) 5721 2176  
Dr Brian Hollins (03) 5762 1022  
Dr Olivia Stuart (03) 5750 1000  
Dr Greg Louis (03) 5772 1444  
Dr Pradeep Dissanyake (03) 5722 1500  
Ms Nicki Melville (02) 6021 1739

## MOUNT BEAUTY OFFICE

P.O. Box 500 Mount Beauty Vic 3699

Phone: (03) 5754 1226

Fax: (03) 5754 1225

Chief Executive Officer ..... David Dart  
Finance Officer ..... Carol Dale  
Personal / Administration Assistant  
& Web Site Manager ..... Heather Stones  
Clinical Risk Manager ..... Mandy Ditcham

## BENALLA OFFICE

P.O. Box 666, Benalla Vic 3672

Phone: (03) 5762 2444

Fax: (03) 5762 8444

Mental Health Program Manager ..... Natalie Orgias  
Administration Assistant ..... Helen Mansfield  
Youth Health Manager ..... Anne Shaw  
Clinical Dietitian ..... Jo Morshead  
Credentialed Diabetes Educator ..... Janet Lagstrom

## Business Development Team (BDT)

Education & Immunisation Coordinator ..... Holli Davis  
e-health Coordinator ..... Vimal Pasupathy  
Practice Management, Practice Nurse  
& Chronic Disease Coordinator ..... Rosslyn Makin

## WALWA OFFICE

Walwa Bush Nursing Centre Main St, Walwa Vic 3709

Phone: (02) 6037 1405

Fax: (02) 6037 1480

Allied Health & Aged Care Manager, Quality  
Coordinator & BDT Team Leader ..... Sandra Beirs

## OFF SITE

Medical Workforce Officer ..... Peter Wyman  
Phone: 0437 197 133

## **HEIGHT ADJUSTABLE BEDS**

**PapScreen Victoria would like to remind practices to have height adjustable beds available to their patients.**

Does your practice have a height adjustable examination bed?

Is it located in a room accessible to all practice staff?

*The RACPG Standards for General Practices* (4<sup>th</sup> edition) now requires accredited practices to have at least one height adjustable examination bed.

These are best located in a treatment room to avoid patients, particularly those with a disability and the elderly, having to wait for access to the bed.

 Women with disabilities victoria  
empowering women



### **Indemnity**

Although every effort has been made to ensure that material provided by North East Victorian Division of General Practice (NEVICDGP) is accurate and up-to-date, NEVICDGP does not warrant the quality, accuracy, or completeness of NEVICDGP material contained in this document. If you place any reliance on NEVICDGP material, you do so solely at your own risk and hereby indemnify NEVICDGP from and against all actions, claims, suits, demands, damages, liabilities, costs or expenses arising out of or in any way connected to the use of any third party material. Any liability incurred by NEVICDGP is hereby limited to the fullest extent permitted by law.

### **Third Party Material**

This document may include information, text, graphics, logos, products or services from third parties ("Third Party Material"). NEVICDGP makes no warranties or representations regarding the quality, accuracy or completeness of Third Party Material or that Third Party Material does not infringe the intellectual property rights (including copyright, trade mark or design rights) of any person. Accessing and use of, or reliance upon, Third Party Material is solely at your own risk and NEVICDGP accepts no responsibility and will not be liable for any loss or damage whatsoever that you may suffer as a result, including damages for loss of profits, business interruptions, lost data or any other direct, indirect or consequential damages.

### **Complaints Mechanism NEVICDGP**

If General Practitioners, Practice Staff, Members of the Public wish to view the policies regarding complaint/ grievance process or they wish to lodge a complaint against the North East Victorian Division of General Practice, please contact the Executive Officer, David Dart on 03 5754 1226. They may also contact the Office of the Health Services Commissioner on 1800 136 066

### **Privacy Policy**

If General Practitioners, Practice Staff, Members of the Public wish to view the privacy policy of the North East Victorian Division of General Practice, please contact the Executive Officer, David Dart on 03 5754 1226. They may also contact the Office of the Federal Privacy Commissioner on 1800 136 066